

BEST PRACTICES FOR SHORT-TERM HEALTHCARE MISSIONS	
Question: How does one avoid a relationship of dependency with a mission partner?	
Participants in discussion	Background (perspective)
Michael Soderling MD Initiator and primary author	
Glenn Schwartz Peter Yorgin, MD	Reviewers
Why is this important? Dependency is one of the means that Satan uses to lessen the power and reach of Christ's church	

Biblical concepts involved

The church is one body and functions best when there is a healthy interdependency and unity present between its members. John 17:21; Romans 12:4, 5; 1 Corinthians 12:12-27; Ephesians 4:1-6.

Self examination. 1 Corinthians 11:28; 2 Corinthians 13: 5

Paul did not undertake his missionary journeys so as to create a dependency on the part of his church plants to a central church authority in Jerusalem.

Introduction

For many years a noted Family Practitioner came to visit the rural Central American mountains where he had been establishing a small hospital to serve the needs of the poor in the area. With each visit more equipment was brought into the country and sent on the long overland journey to this remote village. Healthcare was now available to the village and surrounding areas that had not been available previously. Surgeries were being performed that previously would have required a long journey to the capital city where a long wait would be required to be seen by a poorly qualified doctor who might then recommend a procedure that might be available after a few months of waiting. But in the mountains, things went quite well for the visiting medical doctor. But then this

renowned family practitioner from the USA began to become weary in well-doing and did not visit as often as he once did. He was bringing in fewer and fewer containers of equipment, and the work being done at the small hospital was decreasing. Unfortunately, he had no built-in mechanism for mobilizing local resources as the outside resources decreased. Eventually the good doctor could no longer continue his visits to Central America. On his last visit, he was honored for his great contribution to the community. The facility he built and equipped now lies unused and the equipment has been pilfered for use in the offices of local doctors. This is a sad, but true, story. It is one that could be told many times over in different locations around the world.

What Can We Learn From the Evidence?

What can we learn from this all too common story? Unfortunately, the healthcare facility mentioned above and the work being done there was dependent on one outside physician for its leadership and sustainability. Once that outside support was removed, the work slowly but steadily came to a grinding halt. How many times has this scenario been repeated in the 2/3 world? How much of God's valuable resources have been poured out by the rich West, and our churches, in an attempt to bring relief from disease, poverty and suffering, with seemingly so little to show for the investment? Part of what we can learn from this story and from the history of giving to relieve poverty, is that money and material resources are not the most important answers. It too often leads to unhealthy dependency on the part of those we seek to serve.

It is unlikely that this well meaning physician from the US took the necessary steps to ensure that the local community had taken ownership of this project. The tendency in the West is to think we know what will serve the poor most effectively. Because of our feeling of superiority, look at our technology after all, we often leave out the most important part of what makes mission work sustainable in the long term. And the deficit we often suffer from is a deficit in how we view the poor and how we exclude them from contributing to the good works we are involved in.

In recent years much attention has been given to the issue of dependency in world missions. Two books came out in 2007 which argue from seemingly different sides of the same coin as to how Christians are to go about using the resources the Lord has given to them. In his book, *To Give or Not To Give*, author Dr. John Rowell argues that Christians are not giving nearly enough money to the church for the purposes of reaching the lost with the gospel of Christ or for the alleviation of poverty (1). Statistics show that in 2002 only 6% of evangelicals gave 10% of their income (tithed) to the church - a 50% drop from just two years prior. It is estimated that seventy to eighty billion dollars would be enough to help meet the most basic needs of the world's poor. He believes that if evangelicals were to give the biblical tithe, poverty could be eliminated with sixty to seventy billion dollars left over for evangelistic efforts to bring the Good News to the unreached people groups of the world. Dr. Rowell proposes a "Missionary Marshal Plan," to mobilize billions of western dollars in order to alleviate poverty around the world. His assumption is that it is money from North America and other rich countries that will solve the problem of poverty in the rest of the world. Taking into account the failure of massive amounts of outside funding to create positive change in a country like Haiti, it would seem this line of thinking is not supported by the evidence. This is not to say that material resources should never be used. But the way in which the resources are being used needs to undergo careful review and modification.

A recent book by the well known economist Jeffrey Sachs has received much attention in the academic world. From his wealth of experience Sachs argues in, *The End of Poverty, Economic Possibilities for Our Time*, for the same type of solution to the world's poverty. (2) Spend more money. Sachs' book is worth the read but in the end the argument is still the same. The West has not spent enough money to bring about significant reduction in the rate of extreme poverty.

But serious questions have arisen in the secular world about why there has been so little progress in the fight against world poverty after so much money has been spent. A fascinating book by William Easterly is the best attempt yet to identify, from a non-Christian worldview, why this is the case. In his book, *The White Man's Burden; Why the West's Efforts to Aid the Rest Have Done So Much Ill and So Little Good*, Easterly highlights the fact that the West has spent some 2.3 trillion dollars over the last 50 to 60 years with very little to show for the investment. (3) His main point is that what he calls the Planners, those

in the West who have the resources and thus make the plans, do not know how best to go about fighting the problems they seek to combat. It is the Searchers, those on the ground with local knowledge of the culture, who really know what plans will work most effectively. But for the West to connect and exploit, in a good way, this type of local knowledge of what will work best, the West must be willing to humble themselves and recognize that the poor really do have something important to contribute. If we don't do this we will continue to drag the poor into the dependency trap.

On the flip side of this coin is the opinion given by Glenn Schwartz in his book, *When Charity Destroys Dignity: Overcoming Unhealthy Dependency in the Christian Movement*. (4) Schwartz writes from his years of missionary experience in Central Africa. He witnessed first hand the way in which western funding often binds poor churches and communities, resulting in a sense of fatalism among those the outside funds are intended to help. He believes this robs believers in many communities of the joy of giving toward their own needs. They are often deprived of the sense of satisfaction that comes from mobilizing resources that are within arm's reach in their own communities. Schwartz writes that a more healthy progression in the fight against poverty is not to look first to global resources to solve problems, but to think first of mobilizing local resources. Another story may help illuminate this better.

The ten year old child begins to have vague but constant abdominal pain during church services on Sunday. The poor family, who survives on subsistence farming, believes it is another case of parasites, which their children have suffered with before, and which the health centers doctors have explained to them during previous visits. They give the child some left over medication they were given last year by the visiting foreign doctors and which they were told would kill the parasites. But the pain continues and over the next couple of days worsens. The foreign doctors are due back again next week and the family decides to wait to have the child examined by this team again rather than go to the local governmental health center. The pain becomes too unbearable and one night they decide they must take the child to be examined at the local health center. The nurse on duty thinks it might be a case of appendicitis but since the

government doctor won't be back to this village clinic for another two weeks she sends the family to the nearest governmental hospital where the child dies from a ruptured appendix.

This type of dependency thinking, that it is only the foreign doctors that will be able to accurately diagnose and treat this child's pain, is what we too often see in the 2/3 world we work in. The best progression in this scenario would be for the family to have enough confidence in the local healthcare providers to think that that is where they should go first to have the problem taken care of. But we too often do not include local healthcare providers in the short term healthcare outreaches we conduct and so establish and perpetuate the attitude of dependency on foreigners to solve problems. Schwartz believes the progression for meeting local needs should be; the individual, then direct family members, extended family members, the local church, the local community, regional resources (on a departmental level), national resources and finally and lastly, global resources.

While some may think Rowell and Schwartz are in direct opposition to each other I believe both make very important arguments that the worldwide church must give attention to. I believe both would agree that those who name the name of Christ as Lord should be giving generously for the work of God's kingdom. I also believe both agree that unhealthy dependency is to be avoided whenever possible. The challenge, in my opinion, is to find a healthy interdependency that builds strong relationships with those we are seeking to serve. Avoiding or overcoming unhealthy dependency has an important bearing on providing healthcare through both long-term and short-term missions. The stories I have used in this article are examples of the kind of unhealthy dependency that should be avoided. Since I am writing primarily about short-term cross-cultural healthcare, what can be done to avoid unhealthy dependency? The following are a few recommendations for anyone involved in short-term healthcare work.

1. **Examine your motives** for doing healthcare missions on a short term basis. There are many who have been called to a fulltime healthcare mission

commitment but who feel they can satisfy this calling by doing a one or two week “mission” trip each year. Joel Belz, in an article in World Magazine, has written about this recent trend and its roots. (5) We must also assure that we are not functioning with an attitude of superiority over those we seek to serve. Romans 12:16 states; “Be of the same mind toward one another; do not be haughty in mind, but associate with the lowly. Do not be wise in your own estimation.” Our motives must not be to alleviate guilt we might feel for living a very comfortable lifestyle in the US. In the book I mentioned above, Glenn Schwartz has several chapters (18, 21 and 23) in which he deals with attitude and demeanor in relation to cross-cultural missions. (Some are specifically related to short-term missions.) He shows that the attitude and beginning assumptions of cross-cultural workers – both medical and non-medical – will most likely determine whether unhealthy dependency develops.

2. **Evaluate your own views on the poor.** A review of Bryant Meyers book, *Walking With The Poor*, is an excellent place to start. The world tends to see the poor as an abstract group that can do almost nothing for themselves and we too often use this as an excuse to play God in their lives. When we reduce the poor to an abstraction we deepen their poverty and our own. We must see the poor as people who are made in the image of God, as we are. They have been gifted by God with certain abilities and with a wealth of knowledge which we must mobilize.
3. **Assess your views of poverty.** In his book, Meyers highlights several points of view with regards to the question of what is poverty. It is not just a lack of things. It also includes physical weakness, isolation, powerlessness, and a lack of social power. It can also be seen as entanglement in a web of lies. And these lies will tend to foster in the minds of the poor, a dependency on the West to provide for their needs.
4. Do a **pre-trip assessment** of the area in which you believe God has called you to serve. This will be important for building the long-term relationships that are necessary for sustainability in the future and it must be used to establish the VISION that will drive the work well into the future. This assessment might include a mapping project to become familiar with the area and to learn about what other healthcare options exist in your service area. This trip can be used to

meet with government healthcare officials with whom you will want to collaborate in the future. During this time you will also have the opportunity to meet with local church leadership. Don't ignore other resources in the community that can be enhanced by developing good working relationships. Consider developing relationships as an opportunity to demonstrate the Good News of Jesus Christ – a benefit that will go far beyond the two-week medical mission trip. After all, you want local people to remember your visit positively long after the short-term team has been there. It is helpful if someone from the senders category attends one of these vision trips as well.

5. **Base your work on what your local partners (the Searchers in Easterly's terms) deem most important and urgent.** This is vision casting that ideally should be agreed to with a priority given to local initiative. We must avoid perpetuating the thinking that the West knows best. We must humble ourselves and put our resources and knowledge at the disposal of the local partners. Of course, this is a complex matter because where prolonged dependency is entrenched, it may take some prayerful creativity to help people see their way out of the resulting discouragement and disillusionment. If they are deep into unhealthy dependency, they may not be capable of creating long-term vision setting. Sensing when this is the case requires a level of cultural and spiritual sensitivity. The long-term goal should be to produce what Schwartz calls "Psychological Ownership" on the part of those we seek to help (page 12 and following).
6. **Build strong relationships in order to do true partnership.** Kingdom partnerships for releasing power and restoring hope, is the theme of a book by Phill Butler, the leading authority on effective networks and partnerships. His book is called "*Well Connected*," and goes into the nuts and bolts of doing true partnership. (6) Daniel Rickett's book "*Making Your Partnership Work*," (7) is another good tool in this respect.
7. **Use appropriate technology.** This would include using basic medications consistent with WHO standards and not the latest medications which will not be able to be obtained after you leave.
8. **Make sure you keep the main thing the main thing.** As Christian healthcare workers our goal should at all times be to make Christ known to unbelievers.

Jayakumar Christian, an Indian development worker is quoted in Meyers book as saying “whatever we put at the center of the program during its lifetime will tend to be what the community worships in the end. (page 207) If we put ourselves and our Western emphasis on curative care and technology at the center of our work then this is what will be worshipped after we leave.

9. **Place an emphasis on healthcare education.** The short term model of taking highly trained healthcare workers to a week of work seeing as many patients as possible before returning home, with no attempt to improve the knowledge base in the communities in which you serve should be completely scrapped. This education may include workshops for local healthcare workers be they Christian or not. It may also include training in such things as healthcare management. And again these should be open to all.

Sender Perspective

Before - Prayerfully consider where it is the Lord is leading you to work in the area of healthcare missions. Consider making this area your long term commitment where you hope to effect measureable and sustained improvement in the health of the people. Have at least one individual be a part of the “Vision” team that does a preliminary visit to the country to which you are called. It will be important to help establish the “Vision” for it to be accomplished. Become thoroughly knowledgeable about conditions in the host country. Be up to date in your missiology.

During – Pray as the teams are in the field doing the work. Communicate as often as necessary with those being sent and those who will be receiving your team.

After – Take part in the post trip assessment. Celebrate the successes and learn from mistakes.

Goer Perspective

Before – Prayerfully assess whether this is the organization with which the Lord would have you work and in the part of the world He is calling you to work. Examine your personal motives as well as your attitudes toward the poor and poverty. Make sure the Lord is not actually calling you to a full-time commitment to foreign healthcare missions. Be prepared to be a learner. Prepare to teach what local people have indicated they would like to learn more about. This could be just head knowledge about medical treatments or could include teaching new techniques appropriate to the setting.

During – Maintain the same level of medical ethics standards as you would in your home setting. Make every effort to make the local people you are working feel as though you are working as equals. Demonstrate real interest in them, their family, and their communities. Be a good listener and demonstrate a desire to learn. Be patient and do not assume a posture of trusting others only when they have demonstrated trustworthiness. Trust first. Teach with an attitude of equality with your listeners.

After – Attend post trip sessions to evaluate how the trip went and to discuss future improvements. Spread the word about what you have seen the local people doing for themselves. Only share about what you did when asked.

Host/Recipient Perspective

Before – Conduct a thorough assessment of the community's assets. Try to determine whether the area is suffering from the dependency syndrome. The host should also self assess in this respect. If the host is a church, make every effort to network with other churches in the area so as to maximize impact and to help others overcome dependency. Meet with "Vision" team of Senders and Goers. Help establish the vision that will conduct the work well into the future. Employ prayer groups from the local body of believers to be regularly interceding for the project. Especially that any spirit of dependency can be overcome.

During – Help maintain an acceptable level of orderliness during the work. Help recognize and squelch any conflicts between local workers and visitors. Show patience towards the

visitors who may be having their first experience with third world poverty. Keep the main thing the main thing.

After – Partake in a brief debriefing with the visiting team members. Do all follow-up as deemed necessary. Especially assure that spiritual follow-up is maintained for those who may have made a verbal commitment to Christ.

Conclusion

Glenn Schwartz, whom I quoted earlier, suggests that there are some similarities between short-term medical missions and cross-cultural church planting. Think of it this way. Church planters go out into the world to share the Good News of the Gospel. As they go, they are not only looking for converts, they are recruiting people to help in the crusade as they march across the world. They want helpers who will join the ranks and help to further the task. Health workers should look at the process in a similar way. They should be looking for like-minded people who can join the ranks and carry on the work whether or not anyone else is present. Ideally they should be learning to do this with the resources God has provided close at hand. This is incredibly important so that not everything stops when the outsiders are not present.

What is the alternative? Too often, the Gospel has been preached (or medical work has been done) in such a way that the recruits become attracted to the process, not for what they can give, but for what they can get. This means that they are not speeding up the cause, but rather slowing it down. They are becoming an added burden as the crusade moves forward. Little wonder that many efforts get bogged down along the way and cannot afford to keep moving on. They do not gather helpers; they gather burdens – slowing down the pace of the enterprise. That is an expensive way to do church planting, and it is an expensive way to do medical missions.

Much has been written about short-term missions, including medical teams. While many have pointed out the negative side of poorly run medical missions, there is ample evidence that many positive benefits can accrue. The challenge is to do short-term medical missions in a way that gathers recruits for the battle and not additional burdens.

CONSENSUS STATEMENT

1. Make every effort to ensure that the motivations for going on a short-term healthcare trip are in line with Biblical teaching. Be aware of your attitude toward the poor and in tune with your beliefs about poverty.
2. Arrange a pre-trip assessment of assets already available in the area to which plan to go.
3. Together with all parties involved, establish a vision for the work you are planning to do.
4. Craft your partnership with a goal of creating healthy interdependency which benefits all parties.
5. Encourage local leaders to take advantage of educational opportunities that will allow them to continue the work when fatigue or something else overtakes the outsiders.

References

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